1616 SW Sunset Blvd., Suite G Portland, OR 97239
503.246.9802
www.GarfinkleOrtho.com

Dear: ____

We are pleased that you chose our office for your orthodontic treatment. We appreciate and value the trust you've placed in us and will strive to meet and exceed your expectations. At your first visit the doctor will perform an orthodontic evaluation and discuss treatment alternatives. Please allow for a one-hour visit.

We have enclosed this Health/Dental History questionnaire. The doctor will review this carefully. For your convenience, please consider filling this out at home. Thank you.

We are looking forward to seeing you on: DAY __________ DATE ___________ at TIME __________ am / pm

Sincerely, ______________________________________

Patient Registration

Patient's Name: ____

Date of Birth: _______/_______/________ SSN (Adult patients only): __________-_________-__________

Home Address Street: ____

City: _______________________________ State: __________ Zip: ____________

Years at this address: _________________

Phone Home: ( ) _______________________ Other: ( ) ____________________

Email (for appointment reminders): ____

If patient is a minor, who is legally responsible? _________________________________

Employer: ____ Number of Years Employed: ________

Social Security Number: ____________-_________-____________ Birthday: ________-________-________

Spouse's Name: ____________________________________ Relationship to Patient: ____________________

Employer: ____ Number of Years Employed: _________

Social Security Number: ___________-_________-____________ Birthday: ________-________-________

In case of emergency, who should we contact? _______________________________________

Phone: ( ) __________________________ Relationship: _________________________________

Who may we thank for referring you? ____

Dental Insurance Information

Primary Dental Insurance:

Name of Insurance Company: ______________________________ Phone: ( ) _______________________

Insurance Address: ____

Subscriber's Name: ___________________________________ SSN or Sub ID: _________________________

Date of Birth: _______-_______-________ Group or Policy Number: ___________________________________

Secondary Dental Insurance:

Name of Insurance Company: ______________________________ Phone: ( ) _______________________

Insurance Address: ____

Subscriber's Name: ___________________________________ SSN or Sub ID: _________________________

Date of Birth: _______-_______-________ Group or Policy Number: ___________________________________

Health History

Form Complete By: ___________________

Are you presently under the care of a physician? Yes No

If yes, for what conditions: ____

____

Name of Physician: ______________________________ Phone: (   ) ______________________

In the last five years, have you ever been:

Hospitalized	No	Yes
Had a serious illness	No	Yes
Had a major operation	No	Yes

Have you ever had, or do you presently have any of the following conditions? (If "Yes", please describe below)

Heart Surgery, Heart Disease, or Heart Attack	Yes	No	Thyroid Disease	Yes	No
Angina Pectoris/Chest Pain	Yes	No	Ulcer	Yes	No
High/Low Blood Pressure	Yes	No	AIDS or HIV positive (STDs)	Yes	No
Heart Murmur	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Rheumatic Fever/Rheumatic Heart Disease	Yes	No	Blood Transfusion	Yes	No
Congenital Heart Lesions/Mitral Value Prolapse	Yes	No	Drug Addiction/Alcoholism	Yes	No
Artificial Heart Valve	Yes	No	Hemophilia or Excessive Bleeding	Yes	No
Heart Pacemaker	Yes	No	Use of Fen-Phen, Redux, or diet pills	Yes	No
Artificial Joint/Prosthesis	Yes	No	Use of Coumadin or blood thinners	Yes	No
Stroke	Yes	No	Organ Transplant	Yes	No
Kidney Disease	Yes	No	Psychiatric Treatment	Yes	No
Cancer or Tumors	Yes	No	Allergies/Hay Fever	Yes	No
Radiation Treatment of the Head or Neck	Yes	No	Asthma	Yes	No
Lung Disease/Tuberculosis	Yes	No	Sinus Trouble	Yes	No
Diabetes	Yes	No	Seizures/Epilepsy	Yes	No
Jaw Joint (TMJ) Problems	Yes	No	Arthritis	Yes	No
			Osteoperosis	Yes	No

Please explain health conditions:

____

____

Have you ever had an allergic or unusual reaction to any of the following?

Latex Materials	Yes	No
Penicillin	Yes	No
Erythromycin or Other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Nickel	Yes	No
Any Other Medication or Drugs	Yes	No

Which Ones? ____

Women: Are you Pregnant?	Yes	No	If Yes, How Many Months? ___________
Are you Breast feeding?	Yes	No	
Are you Taking Birth Control Pills	Yes	No	

If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication. Therefore, if you are prescribed antibiotics during orthodontic treatment, additional birth control methods should be used until your next menses.

Please list any medications (over the counter or prescription) that you are now taking:

____

____

If you have ever had any serious complications involving dental treatment, please explain:

____

____

Dental History Form Complete By: ________________

Family Dentist: ____

Primary concern (why are you interested in braces?): ________________________________

How many times per day do you ***BRUSH*** your teeth? 0 1 2 3+

How many times per day do you ***FLOSS*** your teeth? 0 1 2+

History of:			Specifics of Problem If ***Yes***:		Please explain all ***Yes*** answers:
Tooth Injury	No	Yes	Chipped / Broken / Lost		____________________
Jaw Injury	No	Yes	At Age: ________		____________________
Oral Disease	No	Yes	Ulcers / Sores		____________________
Jaw Joint Pain	No	Yes	Right:	Constant / Periodic	____________________
			Left:	Constant / Periodic	____________________
Jaw Joint Noises	No	Yes	Right:	Click / Pop / Grating	____________________
			Left:	Click / Pop / Grating	____________________
Jaw Joint Locking	No	Yes	Right:	When Open / Closed	____________________
			Left:	When Open / Closed	____________________
Grinding Your Teeth	No	Yes	During Day / When Sleeping		____________________
Clenching Your Teeth	No	Yes	During Day / When Sleeping		____________________
Bleeding Gums	No	Yes	Brushing / Flossing / Eating		____________________
Oral Habits	No	Yes	Thumb Sucking / Finger Sucking / Tongue Thrusting / Nail Biting		
			____		
Other Oral Problems	No	Yes	____		
			____		
Headaches	No	Yes			
Snoring/Sleeping Issues	No	Yes	____		

Have you ever had:			What kind of treatment?	Doctor seen:
Periodontal (gums) Treatment	No	Yes	________________	________
Orthodontic (braces) Treatment	No	Yes	________________	________
Endodontic (root canal) Treatment	No	Yes	________________	________
Oral Surgery (jaw surgery) Treatment	No	Yes	________________	________
Prosthodontic (crown & bridge) Treatment	No	Yes	________________	________

I hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time and that I have also received a copy of this office's Notice of Privacy Practices. If there are any future changes in this information, I will inform this practice of these changes. I understand that credit bureau reports may be obtained for financial purposes (your credit will not be affected).

____

Patient Signature (or Guardian) Date

____

Doctor Signature Date of review

____

Treatment Coordinator Signature Date of review